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UNITED NATIONS CHILDREN'S FUND
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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Mauritania

The Executive Director recommends that the Executive Board approve an amount of $5 million from general resources, subject to the availability of funds, and an amount of $7,253,000, in supplementary funds, subject to the availability of specific-purpose contributions, for the Mauritania country programme for the period 1994-1998.

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* In order to meet documentation deadlines, this document was prepared before aggregate financial data for the year were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1992, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/P/L.2 and Add.1).

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SITUATION OF CHILDREN AND WOMEN

1. For almost 30 years, Mauritania, a developing country situated in the Sahel-Saharan region, has been experiencing rapid desertification. The per capita gross national product (GNP) of US$ 510 should be viewed with some caution in view of the unequal distribution of income and the concentration of development poles.

2. Mauritania is one of the most indebted countries in the world in relative terms (225 per cent of its gross domestic product in 1991). Its mining industry, the main source of employment, currently operates in a difficult international environment and is no longer profitable. It now functions mainly to service the country's debt. Fishing, the second pillar of the economy in the mid-1980s, is also experiencing serious problems due to the dilapidation of the fleet, the over-indebtedness of operators, and the over-exploitation of resources. The programme of structural adjustment launched in 1985 has exacerbated a social situation already made precarious by the drought which led to mass migration from rural areas, rapid and uncontrolled urbanization, severe pressure on ill-equipped urban services and the steady deterioration of their quality, and the impoverishment of the vast majority of the population. In the wake of the economic crisis and the resulting structural adjustment programme, the budgets of the major social sectors, including health and education, have decreased in real terms and now cover little more than the wage bill.

3. In the last quarter of 1991, a programme of democratization was initiated, which culminated during the period from January to April 1992 in successive elections for the presidency, legislature and senate. The result was the creation of political institutions consistent with the new Constitution. The resumption of diplomatic relations with Senegal in May 1992 was followed immediately by the reopening of the border between the two countries, which had been closed since 1989.

4. Among the immediate tasks facing the new Government was the very difficult challenge of putting public finances and the country's economy back on a sound footing while maintaining social peace. In October 1992, the country was forced to devalue its currency by 28 per cent; approximately 35 per cent of the active population is currently unemployed and this number is likely to increase. As a result of falling demand, employment in the craft, informal and modern sectors has decreased significantly. Against this background of continuing economic crisis, a rise in poverty levels is probably unavoidable since the levels of income that funded transfers through family and tribal channels, thus ensuring the survival of a large segment of the population, have reached a low point.

5. More than two thirds of the territory of Mauritania is desert which for some years now has been advancing at an estimated rate of 6 kilometres per year and has severely disrupted Mauritanian society. Specifically, it has forced its nomadic population, whose numbers fell sharply from 78 per cent to 12 per cent between 1965 and 1988, to become sedentary. The country has also

experienced the socio-economic consequences of the desert's encroachment on the Sahel region to the south and south-east (where almost 80 per cent of the population lives). These include the phenomena of rural depopulation, rapid urbanization, the explosion of shanty-towns around urban areas and a growing food deficit.

6. In these difficult ecological, economic and social circumstances, mortality rates remain very high. The infant mortality rate (IMR) is 120 per 1,000 live births, the child mortality rate 209 per 1,000 and the maternal mortality rate (MMR) between 450 and 500 per 100,000. Random samplings have shown that these rates are higher in poor rural and peri-urban areas where the IMR was 176 in the Gorgol region in 1991 and 245 in the shanty-towns of Nouakchott in 1988, respectively. The Mauritanian Government has so far been unable to provide the population with a truly effective health-care system. The weakness of that system is apparent from the limited access to services, the lack of personnel in rural areas, the inadequate and dilapidated state of the infrastructure, and the shortage of drugs, supplies and equipment.

7. The supply of drinking water, a vital element in the promotion of health care, is a major problem in Mauritania. In urban areas, only nine towns, which account for a fraction of the population, are equipped with water supply systems. According to 1991 estimates, barely 20 per cent of the population of Nouakchott have household water mains, while a small part of the remainder of the population obtain water from standpipes and most of the others, particularly the populations of poor peri-urban areas, obtain their water supply from vendors. The cost of water is very high in towns, and, paradoxically, the cost of water transported by cart is US$ 8 per cubic metre, which is 10 times higher than the price paid by those with domiciliary connections. The poor conditions of reservoirs and facilities for the transport of water in both urban and rural areas cannot guarantee the quality of water. Standards of hygiene and sanitation, particularly for the disposal of waste and excrement, are low. Generally speaking, the country's population is directly exposed to faeces and its attendant dangers (incidence of diarrhoeal and parasitic infections).

8. Malnutrition, mainly energy protein deficiency, is endemic in Mauritania. The incidence of general malnutrition, based on a number of surveys carried out over the last 10 years, is approximately 40 per cent, of which 6 to 8 per cent are cases of advanced malnutrition. Between 30 and 60 per cent of newborn infants, depending on the ecological area, suffer from low birth weight. According to 1988 estimates, 18 per cent of children under five suffer from wasting (the rate is higher in Nouakchott) and more than 48 per cent suffer from stunted growth.

9. Mauritania has an unusual educational system which relies upon both basic and traditional schooling. Considerable efforts have been made over the past 10 years to bring school enrolment up to 51 per cent, but the illiteracy rate, at 66 per cent, remains high. Traditional schools, which are an integral part of rural life, play an important role in the education system. The education budget accounts for 22 per cent of the national budget; 33 per cent of the

education budget is allocated to primary schooling, 72 per cent of which goes to pay salaries and only 22 per cent is spent on teacher training. The education of girls presents a problem. Girls account for only 40 per cent of the school population and their dropout rate in the first cycle is 80 per cent.

10. Mauritanian women have been gradually consolidating their status as citizens through greater assertion of their rights under the Constitution and their increasingly frequent participation in administrative and commercial activities. Since they target mainly rural women, programmes for the advancement of women have focused mainly on revenue-generating activities and functional literacy. Even though the maternal mortality rate (MMR) is high, it still appears to be underestimated when compared with the rates in neighbouring countries. A major effort must be made in terms of personnel and infrastructure to deal with high-risk pregnancies. The fertility rate (6.5 children per woman) is still very high and increases the risk.

11. The phenomenon of street children, while not yet fully documented, seems to be on the rise in Mauritania. This is a direct consequence of drought-induced migration, growing urbanization, spread of slums, decline in incomes, the breakdown of family structures in urban areas and the lack of adequate resources for social programmes. According to the International Confederation of Catholic Organizations for Charitable and Social Action (CARITAS), 400 young people, 10 per cent of whom engage in prostitution, roam the streets of Nouakchott.

PROGRAMME COOPERATION, 1989-1993

12. The 1989-1993 programme was designed to help achieve the following objectives: (a) reduce infant and maternal mortality rates; (b) improve the status and living conditions of the most disadvantaged mothers and women; (c) promote food production, education, the advancement of women, child spacing and support for displaced persons, particularly street children; (d) improve and expand national capacity for identifying, planning, managing and monitoring the priority problems of children, youth and women. Cooperation during the period under review was expected to lead to the implementation of the following three programmes: health, basic education and community development in rural and peri-urban areas (Nouakchott).

Health

13. During the period 1988-1989, UNICEF assisted in the development of priority programmes (expanded programme of immunization (EPI), the campaign to combat diarrhoeal diseases and the campaign against blindness) and more generally, maternal and child health. In 1990, the new policies of the Government inspired by the preparations for the health/population project supported by UNICEF, the World Bank, the African Development Bank (AfDB) and the United Nations Population Fund (UNFPA), with German and French cooperation, in conjunction with the Bamako Initiative strategy, helped to reorient the health programme by placing the emphasis on the decentralization of services and methods of integrating activities, community participation in

decision-making and financing and partial recovery of costs through the use of essential drugs.

14. EPI coverage was expanded significantly by acceleration of the mobilization process and the involvement of the Government, the Arab Maghreb Union, local authorities and the people. The total number of immunized people is still very low but the gratifying figures obtained for measles, tuberculosis, diptheria, pertussis and tetanus immunizations augur well for better results in the near future. The lowest rates of coverage are for the rural areas served by the mobile teams. The main obstacles to providing wider immunization coverage to people in remote areas are difficult access, logistical constraints and the cost of the strategy. Other constraints to the smooth implementation of the programme have been poor management of logistical supplies and equipment and the poor quality of services provided (lack of skilled personnel, shortage of equipment and improper sterilization of what equipment is available).

15. Beginning in 1990, UNICEF concentrated on operationalizing the Bamako Initiative in order to speed up primary health care delivery in Oua Naga and Kankossa (the two pilot areas); its action in the Tagant area was carried out with the assistance of the German cooperation agency. The establishment of two national pilot areas helped to: (a) shape national health policy; (b) test the concepts of decentralization, community participation and essential drugs in basic health units, health posts and centres; (c) design the tools needed to popularize the concept of the Bamako Initiative (primary health care training manual, clinical and therapeutic training manual, reform of the health information system); (d) address the global problem of development by complementary activities in the areas of nutrition, water supply and desertification control; (e) consider ways of reducing the cost of social benefits and generating community savings.

16. UNICEF has geared its support to the implementation of the Bamako Initiative in 3 health centres, 2 health posts and 39 community basic health units. In the light of the results, the Council of Ministers issued a decree authorizing local communities to co-finance and manage their health services through management committees in each health establishment. Other measures were adopted in conformity with the policy guidelines of the Bamako Initiative and of the preparatory phase of the health/population project, namely, (a) decentralization of the management of the health care system; (b) mobilization of resources for the regional health care system; (c) national capacity-building; and (d) establishment of an essential drugs policy.

Basic education and functional literacy

17. In view of the Government's policies, the substantial increase in the education budget and the involvement of the World Bank and AfDB in this sector, UNICEF focused on specific activities such as the development of educational activities that promote awareness of the environment, the

establishment of a national health education programme and the production of school textbooks on these topics. An evaluation of this programme in 1990 showed that the programme had not been included in enough class schedules, the training personnel had not digested the themes and the teaching material had not been used properly. However, it confirmed that the themes selected were important and a proposal was made to resume the activities of the programme. At the same time, functional literacy activities for adults, particularly women, were strengthened by increasing the number of projects calling for community management capacities and the training of rural community groups.

Regional programmes

18. In order to sustain the decentralization under way and foster the development of community-based multisectoral activities in rural areas, the 1989-1993 programme supported a project in the Fleuve region aimed at improving the health and nutritional situation, enhancing the status of women in communities by helping to set up and expand women's cooperatives and strengthening the regional social welfare networks. The programme encompassed such basic activities as water supply and sanitation, health, market gardening, irrigated crop cultivation, small-scale livestock-raising and desertification control. The project was successful in improving the organizational and management capacity of some 100 women's groups and in generating a keener appreciation of the role of women's organizations in community decision-making. The concentration of activities made possible an economy of scale in logistical costs and strengthened the impact of the project on the beneficiary communities. These factors are taken into account in the new cooperation programme.

19. It was decided to set up a project in a deprived peri-urban neighbourhood to blunt the consequences of the drought-induced rural exodus which were aggravated by the absence of basic infrastructures to meet the needs of the displaced population. The project activities focused chiefly on establishing a social framework, developing a strategy for action in disadvantaged peri-urban neighbourhoods, and the working out a social welfare master plan. They included assistance to children and single women heads of household living in especially difficult circumstances in the slums of Nouakchott and the building of basic infrastructures for water supply, sanitation, health, nutrition and education. These activities were carried out in collaboration with the other partners, in particular non-governmental organizations including CARITAS and Terre des Hommes. They enabled the Government to organize the social welfare sector, set up safeguards for children morally at risk and provide greater access by the poorest sector to basic services.

Advocacy and social mobilization

20. Advocacy aimed at improving the situation of children and women was undertaken through information and communication activities. The press and television were used to raise public awareness in Nouakchott, and rural radio was used to disseminate educational information to the populations in the

interior. Special media attention was given to important international events like the World Summit for Children and the Day of the African Child, enabling people to keep informed of their progress. Community women's groups and government decision makers were the major targets of social mobilization activities. A national association for UNICEF is being created. Under the auspices of the Arab Maghreb Union (AMU), joint activities are being conducted on behalf of children and women, such as the North African vaccination days that have become a regular annual event. Mauritania was host to the second AMU Symposium on the Child held at Nouakchott on the topic, "Young girls", in December 1992. The observance of the Day of the African Child in June 1992 was the occasion for organizing festivities along the Senegal river, during which peace messages were exchanged by the children of Mauritania and Senegal.

Planning, follow-up and evaluation

21. A system of follow-up and evaluation was envisaged for each project and for the programme as a whole. The system has been only partially developed, and it has not been possible to conduct the annual evaluations initially planned. A mid-term review of the programme was done in August 1990. EPI and the Bamako Initiative have been the subject of regular evaluations.

Emergency programme

22. The nutritional emergency programme focused on the Tagant region in the centre of the country. This region is marked by a very high global rate of malnutrition (64 per cent), the persistence of an insidious nutritional emergency, inaccessibility, and a sharp change in the agricultural potential because of rapid desertification. These factors are to a significant extent responsible for the deteriorating nutritional and health status of children and women and they engender extreme poverty and precarious living conditions. Under the programme, growth-monitoring activities were developed, and more than 1,500 malnourished children and their mothers as well as pregnant women were given food supplements. Food-production or income-generating activities were inaugurated, including the installation of water supply systems, the planting of cultivated plots, herding of milk goats and the equipping of women's crafts groups.

Lessons learned

23. The mid-term review brought out the fact that the programme suffered because of insufficient input by those in charge of sectoral coordination. A greater concentration of activities and a systematic multisectoral strategy would have reduced and rationalized operational (especially logistical) costs, and allowed for more complementary multisectoral activities, creating a synergy that would have enhanced their impact. Still, a clear advantage is gained by simultaneously executing national projects that help shape standardized sectoral strategies and it will be maintained in the new cooperation programme. The new programme will advocate a comprehensive approach reflecting the concerns of the Government and will enable its development partners to expedite national coverage in basic services.

24. Four evaluations were done, two in connection with EPI (in 1989 and 1990) and the two most recent in connection with the Bamako Initiative (in 1990 and 1991). The results, constraints and recommendations were taken into consideration in preparing the new programme.

25. The conflict between Mauritania and Senegal and the situation between Iraq and Kuwait have made it more difficult to raise supplementary funds and have interfered with the implementation of the 1989-1993 cooperation programme. The Government and UNICEF witnessed a steady abandonment of initially scheduled activities. Coordination between the Government and the donors and among the various agencies has improved over the last few months; it should result in more concerted action, a better complementarity in resources and a more cost-effective use of resources in the future.

RECOMMENDED PROGRAMME COOPERATION, 1994-1998

General resources: $5,000,000

Supplementary funds: $7,253,000

Recommended programme cooperation a/

(Thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health and nutrition	1 875	1 829	3 704
Basic education	300	1 576	1 876
Advocacy/social mobilization	300	580	880
Planning, statistics/follow-up and evaluation	200	150	350
Programme support	500	200	700
Area-based programme	1 825	2 918	4 743
Total	5 000	7 253	12 253

a/ A breakdown of estimated annual expenditure is given in table 3.

b/ This figure is in addition to projects to be financed from supplementary funds already available, as indicated in table 3.

Programme aims and objectives

26. The programme of cooperation is in line with Government and UNICEF development policies, including policies specifically designed to improve the status of children and women. Between 1993 and 1995 this programme of cooperation will: (a) reduce the rate of infant-child and maternal mortality through improved access to higher quality preventive, curative and information services and the development of other intersectoral activities affecting the survival of children and mothers; (b) reduce malnutrition among children under five by improving capacity to identify and manage cases and establishing community-based income-generating production activities; (c) improve the quality and effectiveness of basic education by focusing on traditional education and ways to integrate and assure continuity between the traditional and modern education sectors; (d) expand community participation, particularly by women, in the planning, implementation and financing of all programme activities; (e) accelerate community-based literacy campaigns, particularly among women's groups, so as to ensure the successful implementation of activities and improve community-management capacities; and (f) establish a viable system for the collection, analysis and publication of information aimed at monitoring the situation of women and children in Mauritania and improving planning and strategy formulation capacities.

Health/nutrition

27. During the preparatory phase of the health/nutrition programme, particular attention was paid to: (a) analysis of earlier experience (too many vertical projects, not enough extrasectoral and intersectoral coordination in planning and execution, lack of community involvement); (b) assessment of programme feasibility on the basis of EPI results and national pilot zones and the Bamako Initiative (improved access to health services, improved functioning of health service institutions, effective campaign to eliminate the most important direct causes of infant mortality, reliability of community management and establishment of machinery for dealing with the poor and indigent); (c) identification of global socio-economic constraints and specific constraints in the health sector as well as means of removing those constraints or mitigating their impact on the implementation of the programme; and (d) exploitation of opportunities to significantly increase the likelihood of a successful outcome to the programme (rationalization of health policy, its adoption by all donors, effective community participation in pilot zones).

28. On the basis of those operations, a national health/nutrition programme was developed that will help to strengthen the commitment by the Government and UNICEF to extend the national PHC policy based on the concept of the Bamako Initiative and that will directly or indirectly benefit the entire population of Mauritania, estimated at 2,100,000 in 1992.

29. The general programme objective is to reduce IMR by 30 per cent by 1998 as a result of a significant reduction of mortality due to acute respiratory infections (ARI), diarrhoea, malaria and measles, and effective monitoring of the progression of the acquired immune deficiency syndrome (AIDS) epidemic in Mauritania.

30. By adopting a decentralized intersectoral approach and encouraging community decision-making and financial participation, the health/nutrition programme will endeavour to: (a) promote and accelerate the implementation of strategies based on the Bamako Initiative concept through 100 health facilities, with the focus on the 70 existing fixed immunization centres/posts; (b) build on EPI achievements, increasing the effectiveness and ensuring the sustainability of EPI within the framework of the Bamako Initiative; and (c) resume activities to monitor, manage and respond to food emergencies through the health institutions involved in the establishment of the Bamako Initiative. UNICEF assistance to the two projects to be developed will, inter alia, take the form of support for training, supervision, delivery of supplies and equipment and logistical support.

31. The first project, PHC, in keeping with the Bamako Initiative concept, will promote: (a) extension of the national PHC/Bamako Initiative policy and promotion of the minimum activities package; (b) improvement in the quality of services; (c) implementation of the national strategy in 100 health establishments, including the 53 existing departmental health centres; and (d) strengthening of capacities in planning and management, training, information and social mobilization, evaluation and operational research.

32. The logistical aspects of the EPI project will facilitate: (a) maintenance of and improvement in the quality of immunization activities in the 70 existing fixed health care sites; (b) extension of the fixed-site strategy to 30 supplementary health posts and implementation of a semi-fixed-site strategy with regard to 100 health posts that have no cold chains; (c) maintenance of a regular supply of vaccines and immunization equipment, of the central and peripheral cold chains and of central logistical support materials; and (d) an increase in the viability, effectiveness and sustainability of EPI as a result of its consolidation under the Bamako Initiative.

33. The close cooperation enjoyed since 1992 with the World Bank, the African Development Bank, UNFPA and German and French cooperation in the health/population project will be continued and increased in pursuit of the common operational and strategic goals.

Basic education

34. The basic education programme will focus largely on strengthening sectoral planning capacities and seeking innovative approaches in order to accelerate the attainment of the goals established in the field of basic education. The programme will include: (a) a basic education support project which will help to improve access to educational services, strengthen planning capacities and improve the quality of education in Mauritania; and (b) a pilot project in support of traditional education, which is very widespread in Mauritania. Almost 20 per cent of primary schoolchildren are educated in the traditional manner. The project will seek to improve their learning conditions and the results achieved under traditional education while maintaining the identity and specific characteristics of that system. The

strengthening of ties and exchanges between the modern and traditional systems will be encouraged. The project will receive support and, possibly, resources, to be mobilized in the context of Sahelian initiatives. Those initiatives will promote exchanges with other countries in the Sahel facing the same constraints.

Area-based programme

35. The multisectoral area-based programme designed to contain the rural exodus and mitigate its consequences is intended to make high-quality basic services and production tools available to the population of the most deprived rural and peri-urban areas. The aims of the programme are to effect a significant improvement in the socio-economic conditions of those vulnerable groups and to help to slow down the flight from the countryside.

36. In the light of the main findings of the poverty profile survey of Mauritania, the potential for cooperation with other participants, government goals and activities already supported by UNICEF, the disadvantaged peri-urban area of Nouakchott and the wilayas of Brakna, Assaba, Gorgol and Guidimakha were selected for decentralized multisectoral programmes in which the role of the community, and particularly of women, in the identification of needs, planning, co-financing and programme execution will be preponderant.

37. The activities to be carried out involve primary health care based on the Bamako Initiative concept, the protection of children in especially difficult circumstances, nutrition, food security and the promotion of income-generating activities, rural water supply and sanitation, the fight against desertification, basic education and functional literacy and participation in the campaign to eradicate dracunculosis.

38. The integrated area-based programme consists of three projects which will enhance the activities already begun at the national level within the framework of the health and nutrition programme and for which the assistance provided by UNICEF under the national programme (support for training, equipment, logistics and social mobilization) will be supplemented in order to meet the specific requirements of the activities envisaged in the following areas:

(a) Rural development in the Brakna region (wilaya), where there is a community council which oversees basic services, the installation of production tools and the protection of vital infrastructures through the mobilization, organization and participation of communities in decision-making and funding;

(b) Integrated urban basic services covering the outlying areas of Nouakchott where the most deprived population groups live, namely, children in especially difficult circumstances and their families;

(c) The Assaba, Gorgol and Guidimakha regions, where efforts will be focused on combating dracunculosis and increasing health coverage, while setting in motion a trend towards community planning and management through social mobilization.

39. In the Brakna region (population: 215,000) and the Nouakchott district (population: 442,000), where multisectoral programmes affecting most socio-economic sectors will be in force, the programme will help to reduce infant mortality by 50 per cent and maternal mortality by 30 per cent by 1998. In the Assaba, Gorgol and Guidimakha regions (population: 525,000), where a specific project to combat dracunculosis will be executed, simultaneously increasing health coverage, the programme will help to eradicate indigenous dracunculosis by 1996 and to reduce infant mortality by 40 per cent.

40. For each project, the programmed activities will affect health (the Bamako Initiative) in the Brakna region, children in especially difficult circumstances in Nouakchott and the campaign against dracunculosis in the other three regions. All communities served by the programme will be represented by a local development committee in which women and women's groups will be represented. Activities will be coordinated by regional steering committees, in which the communities will be represented.

Advocacy and social mobilization

41. The aim of this programme is to raise awareness, provide more information and mobilize people in order to promote and accelerate the implementation of the national programme of action in accordance with the guidelines of the World Summit for Children. Through an effective use of traditional and modern communication networks, efforts will be made to channel national and international human and financial resources towards the basic sectors, with a view to enhancing the survival, protection and development of children and mothers. Information, education and communication techniques will be utilized to: (a) facilitate the implementation of the Convention on the Rights of the Child; (b) influence behaviour in those sectors which have a definite impact on mortality rates, including AIDS control, the target diseases of the expanded programme on immunization, diarrhoeal diseases, malaria and acute respiratory infections; and (c) mobilize community participation in the process of identifying, planning, co-financing and carrying out activities.

Planning, follow-up and evaluation

42. This programme will consist of two projects: the first will seek to strengthen national and local capacities for analysis of the situation of children and women in Mauritania with a view to adapting programmes to the needs and to ensuring active, periodic follow-up of progress towards the objectives of the national programme of action. The second, which will be geared to the selection, compilation and monitoring of indicators, will make it possible to measure programme impact on the living conditions of children and women. The 1994-1998 cooperation programme will be followed up at three levels: at the national level, the country programme will be monitored by the Ministry of Planning, which will also be responsible for coordination between all the ministries concerned and UNICEF. The Department of Human Resources, whose data-processing capacities will be strengthened, will be responsible for the follow-up of global indicators and the continual updating of the situation

of children and women. At the central level, with the Ministry of Planning as coordinator, the respective technical ministries of the Mauritanian Government will be responsible for the direction, planning, follow-up and evaluation of programmes and sectoral projects in close collaboration with UNICEF technical officers. At the regional level, in keeping with the current decentralization policy, the regional technical services and the local communities concerned will be responsible for detailed planning, co-financing and project execution and management in close collaboration with the beneficiary communities, which will be represented in the regional project steering committees. In the Brakna region, in which a major multisectoral programme will be carried out, a UNICEF technical team will be on duty for the purpose of following up the activities and maintaining the project equipment.

Programme support

43. There will be programme support to cover the cost of the technical personnel required to carry out the planning, follow-up and evaluation of projects and financing in collaboration with the ministries and departments concerned as well as the logistical costs inherent in the follow-up of programme execution and advocacy activities.

Coordination with other partners

44. The programme was prepared in consultation with multilateral and bilateral agencies and non-governmental organizations. That collaboration will be continued and strengthened with a view to a better coordination of activities, taking into account the specific needs and expertise of the partners concerned.

45. The close cooperation with the World Bank, the African Development Bank (AfDB), the United Nations Population Fund (UNFPA) and German and French cooperation partners in executing the health/population project will be strengthened, especially as regards the implementation of the Bamako Initiative and expanded health coverage in the Brakna region and the Nouakchott district.

46. Cooperation among the main participants in the education sector, such as the World Bank and AfDB (the project to restructure the education sector) will generate a better idea of the volume of UNICEF assistance to this programme and facilitate an analysis of the feasibility of the alternative strategies proposed.

47. With regard to water supply, UNICEF will collaborate in the areas chosen for programme cooperation with the programmes funded by the United Nations Development Programme (UNDP), the United Nations Capital Development Fund (UNCDF), the European Community and the Italian cooperation agency. These agencies will be in charge of the works, while UNICEF will concentrate on auxiliary activities, including maintenance, sanitation and the protection of infrastructures, community management and activities around water points. The same complementarity will be sought in the regions where UNICEF has been involved in the fight against dracunculosis.

48. Cooperation with the World Food Programme (WFP), within the framework of activities relating to nutrition and community food security, will be continued as part of the area-based programme, with a greater emphasis on production and nutrition.

49. Rural radio operational and production capacities will be strengthened in close cooperation with German partners as part of the social mobilization and advocacy programme.

50. A joint inter-agency programme will be established in the Assaba region with the participation of UNDP, UNICEF, UNCDF, UNFPA, the Food and Agriculture Organization of the United Nations (FAO), WFP and the World Health Organization (WHO). In the initial phase of this joint programme the efforts of the various agencies will focus on the Assaba region and on identifying joint programming mechanisms, and will be followed by the preparation in 1995 of a joint programme to be submitted to the Executive Board for approval.

Initiatives in the Maghreb

51. On the model of the Maghreb vaccination days which have now become a regular event, other activities will be undertaken jointly by the five member countries of the Arab Maghreb Union, namely, Algeria, the Libyan Arab Jamahiriya, Mauritania, Morocco and Tunisia. The other themes chosen which can provide strong support for the efforts of the Government and UNICEF to protect children and women are: the status of the girl child, pre-school education, safe motherhood and children without families.

Sahelian initiatives

52. Programme cooperation will support two Sahelian initiatives. The first concerns the development, with the assistance of the UNICEF Regional Office, of a common approach by the Sahel countries to the twofold issue of assistance to children in especially difficult circumstances and the promotion of education for all. The other concerns the establishment of an exchange network for purposes of sharing information and experience in order to speed up the development of relevant and sustainable approaches.

53. Within the fr. work of the collaboration begun in 1991 with the United Nations Sudano-Sahelian Office (UNSO), the Government and UNICEF will collaborate in an analysis of the problems faced by the nomadic peoples of the Male district east of the Brakna region. This analysis, which will be carried out in collaboration with the NOPA subregional project (Project for Nomadic Pastoralists in Africa) will lead to the elaboration of a strategy and a plan of action for the development of this traditiona. pastoral area.

Programme management

54. The 1994-1998 cooperation programme is structured at two administrative levels of the Mauritanian Government: at the national level, which is responsible for development policy, programme execution and follow-up and

evaluation; and at the regional level, which is responsible for the management and direct execution of programmes, including area-based programmes at the community level. The management of UNICEF assistance will be decentralized at the appropriate level. A UNICEF technical team will collaborate closely with governmental institutions in order to ensure harmonious programme development and to help achieve the stated aims. National capacity-building will be a priority.

55. The integration and effective coordination of the activities will require technical expertise in the interest of effectively advising the Government on national policy development and implementation. That contribution will make it possible to achieve the primary goal of UNICEF, namely, national capacity-building. To that end, a restructuring of the Nouakchott office is proposed. Two national professional posts in logistics and community development will be reallocated to basic education. For the purposes of management and regular follow-up of the integrated area-based programme activities, a multidisciplinary team consisting of national personnel from the office, will be stationed and on duty in the Brakna region. This team, which will be an integral part of the project steering committee, will also be responsible for complementary follow-up in the Assaba, Gorgol and Guidimakha regions.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Mauritania	(1991 and earlier years)		UNICEF country classification
Under-five mortality rate	209	(1991)	Very high U5MR
Infant mortality rate	120	(1991)	Very high IMR
GNP per capita	$ 510	(1991)	Low GNP
Total population	2.1 Million	(1991)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1991
Births	(Thousands)	58	73	94	97
Infant deaths (under 1)	(Thousands)	10	10	11	12
Under-five deaths	(Thousands)	18	18	20	20
Under-five mortality rate (per 1,000 live births)		292	249	213	209
Infant mortality rate (under 1) (per 1,000 live births)		167	143	122	120

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1991)	Moderate & severe	..	48
	Severe	..	23
Babies with low birth weight (%, 1984)		..	11
% of primary school children reaching final grade, 1980/1988)		80	68

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1981)	.. /../ ..	91 / 86 / 67
Prevalence of wasting (%, 1991)	..	18
Prevalence of stunting (%, 1991)	..	65
Daily per capita calorie supply (% of requirements, 1988-1990)	..	106
Food production per capita index (Index 1979-1981=100, 1980/1991)	99	75
Household expenditure (% of total income) All food/cereals		.. / ..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1989)			54
Access to health services	Total	30	40
(% of population, 1980/1985)	Urban/rural	.. / ..	.. / ..
Access to safe water	Total	16*	66
(% of population, 1980/1988)	Urban/rural	.. / ..	67 / 65
Access to adequate sanitation	Total	..	39
(% of population, 1980/1990)	Urban/rural	5 / ..	69 / 13
Births attended by trained personnel (%, 1980/1988)		15*	20
Maternal mortality rate (per 100,000 live births)		..	..

Immunization		1981	1985	1990	1991
One-year olds (%) immunized against:	Tuberculosis	57	74	75	60
	DPT	18	..	28	26
	Polio	18	..	28	26
	Measles	45	..	33	29
Pregnant women (%) immunized against:	Tetanus	1	..	40	..

TABLE 1 (continued)

Mauritania

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%, 1980/1988)	Total	37 / ..	51 / ..
	Male	47 / ..	60 / ..
	Female	26 / ..	42 / ..
Secondary enrolment ratio (gross/net) (%, 1980/1988)	Total	11 / ..	16 / ..
	Male	18 / ..	22 / ..
	Female	4 / ..	10 / ..
Adult literacy rate, 15 years & older (%, 1990)	Total	..	34
	Male/female	.. / ..	47 / 21
Radio/television sets (per 1,000 population, 1980/1990)		97 / ..	144 / 23

DEMOGRAPHIC INDICATORS		1970	1980	1990	1991	2000**
Total population	(Thousands)	1221	1551	2024	2083	2680
Population aged 0-15 years	(Thousands)	554	718	947	978	1259
Population aged 0-4 years	(Thousands)	214	277	368	380	470
Urban population (% of total)		14	29	47	48	60
Life expectancy at birth (years)	Total	39	43	47	47	51
	Male	38	41	45	46	49
	Female	41	45	49	49	53
Total fertility rate		6.5	6.5	6.5	6.5	5.8
Crude birth rate (per 1,000 population)		47	47	46	46	42
Crude death rate (per 1,000 population)		25	21	18	18	15

		About 1980	Most recent
Contraceptive prevalence rate (%, 1977/1990)		1	4
Population annual growth rate (%, 1965-1980/1980-1991)	Total	2.3	2.7
	Urban	12.4	7.3

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1991)		-0.1	-1.8
Inflation rate (%, 1965-1980/1980-1990)		8	9
Population in absolute poverty (%)	Urban/rural	.. / ..	.. / ..
Household income share (%)	Top 20%/bottom 40%	.. / ..	.. / ..
Government expenditure (% of total expenditure, 1980/1987)	Health/education	2*/ 19*	4*/ 23*
	Defence	..	..
Household expenditure (% of total income)	Health/education	.. / ..	.. / ..
Official development assistance: (1980/1991)	$US millions	176	208
	As % of GNP	29	20
Debt service (% of goods and services exports, 1980/1990)		11	8

* UNICEF field office source.
** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1989-1993 a/

COUNTRY: MAURITANIA
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $4,211,000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
									Actual	Planned	Actual	Planned	Actual	Planned
	GR	FSF	GR	FSF	GR	FSF	GR	FSF						
Health	1027	590	134	100	766	138	751	311	2678	1973	1139	2046	3817	4019
Household food security and nutrition	30	141	1			6	2	8	33		155	1098	188	1098
Water supply and sanitation		96				49		49			194	2277	194	2277
Education	68		19				159		246	530			246	530
Community organization and development	482	224	73	15	320	113	401	343	1276	372	695	3887	1971	4259
Women-centred programme	49		12				6		67	347			67	347
Programme support and development	94				423		215		732	989			732	989
Emergency	97		47		9		224		377	395			377	395
GRAND TOTAL	1847	1051	286	115	1518	306	1758	711	5409 b/	4606 c/	2183	9308 d/	7592	13914

GR = General resources.
FSF = Funded supplementary funding.
SF = Supplementary funding, funded and unfunded.

a/ Actual expenditure includes expenditure recorded as of 17 December 1992.

b/ Including additional general resources allocation for unfunded supplementary funding programmes.

c/ Including $395,000 allocation from the Emergency Reserve Fund.

d/ Of this amount, $3,678,000 remains unfunded.

.../...

TABLE 3. PLANNED EXPENDITURE, 1994 – 1998

(In thousands of United States dollars)

Country: MAURITANIA Period covered: 1994 – 1998	Funding status	1994	1995	1996	1997	1998	Total
Health	GR	375	375	375	375	375	1875
	NSF	454	392	353	326	304	1829
Basic educatien	GR	60	60	60	60	60	300
	NSF	264	346	341	311	314	1576
Social mobilization and advocacy	GR	60	60	60	60	60	300
	NSF	116	116	116	116	116	580
Planning and social statistics	GR	50	45	42	35	28	200
	NSF	30	24	30	25	41	150
Programme support	GR	100	100	100	100	100	500
	NSF	40	40	40	40	40	200
Integrated area–based programme	GR	355	360	363	370	377	1825
	NSF	685	522	693	561	457	2918
TOTAL	GR	1000	1000	1000	1000	1000	5000
	NSF	1589	1440	1573	1379	1272	7253
GRAND TOTAL		2589	2440	2573	2379	2272	12253

GR = General resources.
NSF = New supplementary funding.

TABLE 4. LINKAGE OF PROGRAMME BUDGET AND STAFFING/STAFF COSTS

MAURITANIA

PROGRAMME SECTION/AREAS AND FUNDING SOURCES	PROGRAMME BUDGET, 1994–1998 (In thousands of US dollars)				POSTS a/ and b/ EXISTING POSTS						SUBTOTAL			TOTAL POSTS	STAFF COSTS c/ (In thousands of US dollars)		
	GR	FSF	NSF	TOTAL	D2/L7	D1/L6	P/L5	P/L4	P/L3	P/L2	IP	NP	GS		IP	LOCAL	TOTAL
GENERAL RESOURCES										d/							
Health	1875			1875								3	3	6		894	894
Basic education	300			300													
Social mobilization and advocacy	300			300								1		1		227	227
Planning and social statistics	200			200									4	4		282	282
Programme support	500			500													
Integrated area-based programme	1825			1825				1			1		1	2	670	71	741
TOTAL GR	5000			5000				1			1	4	8	13	670	1474	2144
SUPPLEMENTARY FUNDING																	
Health			1829	1829													
Basic education			1576	1576													
Social mobilization and advocacy			580	580													
Planning and social statistics			150	150													
Programme support			200	200													
Integrated area-based programme			2918	2918						1	1	1	1	3	150	298	448
TOTAL SF			7253	7253						1	1	1	1	3	150	298	448
TOTAL GR & SF				12253				1		1	2	5	9	16	820	1772	2592
ADM. AND PROGRAMME SUPPORT BUDGET (Proposed, 1994–1995)	Operating costs		487				1	1	1		3	2	7	12	790	442	1232
	Staffing b/																
GRAND TOTAL (GR + SF + ADM)							1	2	1	1	5	7	16	28			
	Number of posts and staff costs:																
	– At the beginning of previous programme (1989)										e/ 7	4	11	22	N/A	N/A	N/A
	– At the beginning of proposed programme (1994)										d/ 5	7	16	28	N/A	N/A	N/A
	– At the end of proposed programme (1998) (Indicative only)										6	7	17	30	N/A	N/A	N/A

a/ Each post, regardless of its funding source, supports the country programme as a whole.

b/ The posts are effective as of 1 January 1994.

c/ Project posts are funded for five years and core posts are funded for two years.

d/ Includes 1 UNV.

e/ Includes 3 UNVs

Abbreviations: GR = general resources; FSF = funded supplementary funding; NSF = new supplementary funding; SF = supplementary funding; IP = International Professional; NP = National Professional; GS = General Service; ADM = administrative.

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1993 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Bolivia

The Executive Director recommends that the Executive Board approve the country programme of Bolivia for the period 1993 to 1997 in the amount of $6,875,000 from general resources, subject to the availability of funds, and $34,275,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1992, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. In June 1990, Bolivia became the eighth country in the world to ratify the Convention on the Rights of the Child. The country now faces the task of implementing the Convention, which calls for, among other things, the child's right to survive, the child's right to education and the child's right to adequate nutrition. At present, many Bolivian children are guaranteed none of these rights.

2. The Government of Bolivia took a step towards meeting the needs of the country's children - and in that sense, towards compliance with the Convention on the Rights of the Child - when the President signed the Declaration and Plan of Action of the World Summit for Children. A preliminary version of a 10-year plan of action for children was prepared in 1991. Throughout 1992, the preliminary plan was revised and further developed in preparation for formal adoption as the 10-year plan for children and women.

3. Bolivia has been making progress, but there is still a very long way to go. The infant and under-five mortality rates for Bolivia are estimated at 89 and 126 per 1,000 live births, respectively, for 1991. Both the infant mortality rate (IMR) and the under-five mortality rate (U5MR) have declined since the 1960s, but the rate of decline must increase dramatically if the goals for the year 2000 are to be met. The average annual rate of reduction in U5MR from 1960 to 1980 was 2.2 per cent; in the 1980s the annual rate of reduction increased to 3.2 per cent.

4. The primary cause of child mortality in Bolivia is diarrhoeal dehydration, followed by acute respiratory infections (ARI). Perinatal problems, including neonatal tetanus and other birth complications, are the third leading direct cause of death among young children. Poor nutritional status is an associated cause in most of the deaths of children under five years of age in the country. Vaccine-preventible diseases have, in general, declined in importance as a cause of death in the 1980s, although outbreaks of measles continue to occur and the disease remains dangerous as a precursor of lower respiratory infections. No cases of poliomyelitis have been recorded since 1989.

5. The maternal mortality rate (MMR) is estimated at 600 per 100,000 live births. This figure is 60 times as high as the average MMR of the developed countries of Europe and North America and translates to an estimated 1,300 Bolivian women dying each year of causes associated with pregnancy and childbirth. The relative risk is highest for very young women, for all pregnancies over the age of 40 years and for pregnancies in high parity. Rural women are especially at risk. Illegal induced abortion is reported to be the cause of at least 30 per cent of maternal deaths, but is probably far higher.

6. The overall rate of moderate and severe malnutrition among children under five years of age is estimated at 13 per cent. Malnutrition rates are highest among children aged 6 to 24 months and are associated with inadequate complementary feeding and increased incidence of diarrhoea and respiratory infections. Breast-feeding is the norm, with two thirds of Bolivian children still being breast-fed at the age of one year; the average duration of breast-feeding is 16 months. Child malnutrition in Bolivia is characterized by

the near absence of severe wasting and the very high overall rate, 52.5 per cent, of stunting.

7. Nearly 90 per cent of primary-school-age children in urban Bolivia are in school, but less than one half of children in rural areas attend school. In both urban and rural areas, school attendance rates for girls run about 10 per cent lower than those for boys. Nationally, only one half of the children who enter school complete the primary cycle. Repetition is prevalent; the average number of years of study per grade is 2.1. Bolivia is predominantly a country of indigenous people, where 63 per cent of the population speak an indigenous language. With the exception of a small number of pilot schools, Spanish is the exclusive language of instruction, creating a severe learning obstacle for the majority of rural children who speak only indigenous languages at home.

8. The lack of access to clean water supply and sanitation facilities has been highlighted by the arrival of cholera in Bolivia, although the disease causes far fewer deaths than common diarrhoea among children. About three quarters of the urban population have access to potable water; the figure for rural areas is 27 per cent. Only 40 per cent of urban households are connected to sewage systems, and 13 per cent of the rural population have adequate excreta disposal. Fetching water is considered to be women's work, and in rural areas, it is not uncommon for a woman, perhaps accompanied by her daughters, to spend two hours or more a day at this task.

9. There are some 280,000 working children in Bolivia, most in low-level jobs with long hours and no formal benefits. In many cases, their education has been sacrificed so that they may support themselves or their families. In even more dangerous circumstances are those children who have no families and no homes but the street.

10. In theory, women enjoy equal rights with men; in practice, gender-based discrimination begins at a very early age. The low level of school attendance by girls in rural areas continually produces new generations of illiterate and uneducated women, with only the poorest of opportunities. It is estimated that 85 per cent of Bolivian males above the age of 15 years are literate, but that at least 30 per cent of the women are not. Illiteracy is most common among women in rural areas. It has also been estimated that 70 per cent of the women in the altiplano work 15 hours per day.

PROGRAMME COOPERATION, 1989-1992

11. Over the past four years, UNICEF has contributed to a number of clear achievements for Bolivian children and women. The child has been accorded an important place on the national political agenda with the ratification of the Convention on the Rights of the Child, the signing of the Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s and the subsequent preparation of a 10-year national plan for children and women. In 1989, Bolivia ratified the United Nations Convention on the Elimination of All Forms of Discrimination Against Women.

Maternal and child health

12. In November 1989, three months after assuming office, President Mario Paz Zamora launched a National Plan for Child Survival and Development and Maternal Health, with goals of reducing the prevailing IMR by one half (a reduction later targeted at 85 per 1,000 live births) and MMR by 30 per cent within the four-year administrative period of the Government. The goals were ambitious, but the plan defined Government priorities with respect to health care delivery for children under five years of age and for women of child-bearing age. Preliminary data from the 1992 national census and other projections indicate that IMR has indeed declined nationally over the past four years; however, the new data on MMR is not expected to be available before late 1993.

13. By 1992, Bolivia had attained a coverage rate of 60 per cent for the third dose of the combined diphtheria/pertussis/tetanus vaccine, 70 per cent for the measles vaccine, 70 per cent for the anti-tuberculosis vaccine and 65 per cent for the third dose of the poliomyelitis vaccine. Until 1989, three fourths of all immunizations had been applied on the occasion of national campaign days; with the programme's strengthening of the cold chain, three fourths of all immunizations are now given through the regular health services. The rate of tetanus toxoid vaccination among women of child-bearing age has risen from 8 per cent in 1986 to 52 per cent in 1992.

14. The arrival of cholera in Bolivia in 1991 helped to focus national attention on the danger of all diarrhoeal diseases and, paradoxically, may contribute ultimately to a net reduction in mortality due to diarrhoeal dehydration. More than 5,000 community oral rehydration units were reactivated in conjunction with a massive training, education and mobilization effort. The demand for oral rehydration therapy (ORT), as measured by the number of persons requesting treatment at the community oral rehydration units, tripled from 1991 to 1992.

15. The strategy to control ARI has been threefold: (a) improved case management of pneumonia according to the new World Health Organization (WHO) guidelines; (b) prevention through immunization against pertussis, diphtheria and measles (a common precursor to ARI); and (c) the long-term reduction of risk factors affecting individual children (e.g., low birth weight and malnutrition, particularly vitamin A deficiency, and environmental problems such as indoor and outdoor air pollution, overcrowding and chilling in young children).

16. Birth complications represent the third major cause of child mortality, and an important element of maternal mortality as well. Their reduction is complicated by the reluctance of many women to give birth in maternity facilities, even where those facilities are available. A total of 600 traditional birth attendants (TBAs) have been trained in the detection of high-risk pregnancies and hygienic delivery practices. Simple "clean birth kits" have been provided for home use.

Nutrition

17. More than 1,700 health workers were trained in growth monitoring (including the analysis of results and the communication of those results to mothers), and 1.6 million growth charts and 1,500 scales were distributed, mainly in rural areas. An action-oriented nutrition surveillance system has been established in the departments of Cochabamba and Santa Cruz. The system will eventually expand to all departments of the country, and will include sources of data beyond the health care system.

18. Bolivia was selected as one of the world's 12 lead countries for the "baby-friendly" hospital initiative in 1991, and a formal agreement was reached with the local representatives of all infant formula manufacturers active in the Bolivian market to cease the promotional distribution of breast-milk substitutes throughout the country. A large hospital providing maternity services in the marginal urban areas of La Paz was officially declared as being "baby-friendly", and training in the promotion of breast-feeding was provided to 740 health workers in hospitals throughout the country.

19. The three most common micronutrient deficiencies in the world - vitamin A deficiency, nutritional anaemia and iodine deficiency disorders (IDD) - historically have been prevalent in Bolivia as well. Every year, 325,000 children under five years of age receive vitamin A supplements, both through the regular health services and in connection with national immunization campaign days. Ferrous sulfate supplements are being distributed to some 115,000 pregnant women. In 1982, the rate of endemic goitre among school children was above 62 per cent. The national programme for the control and elimination of IDD has been notably successful in its eight years of operation, with rates of endemic goitre having been reduced to 21 per cent by 1989, and to less than 10 per cent in 1992. Iodated salt is now being produced to meet the needs of more than 80 per cent of the population, and 1,650,000 iodated oil capsules and injections have been administered in areas of the country where iodated salt marketing and consumption have yet to become the norm.

Universal primary education and education for women

20. Primary education in Bolivia is characterized by relatively low enrolment ratios in rural areas (especially among girls), high rates of grade repetition and poor primary school completion rates. Access to schooling continues to be a problem among the widely dispersed rural populations, but advocacy efforts on the need to address that problem and, in particular, the quality and relevance of primary education have been given a boost with the establishment of a full-time working group on educational reform within the Ministry of Planning. The forthcoming educational reform plan is expected to draw heavily on experiences gained from UNICEF-supported initiatives, above all, in intercultural bilingual education. In this project, the child's right to be educated in the context of his own cultural and linguistic background has been recognized. Comprehensive educational materials have now been developed for the first three grades of school in Aymara, Quechua and Guaraní, and notable improvement in school performance, particularly in the reduction of grade repetition, has been demonstrated in the 7,200 children attending 114 pilot schools. The programme has been especially successful among the Guaraní, where it has not only generated renewed interest in adult literacy, but has become a

rallying point for the preservation and promotion of their cultural identity, and the rights of indigenous populations in general.

21. Through the project for non-formal education for women, under the title "women, education and life", 1,200 teachers and promoters have been trained, and some 50,000 participants have been reached in six departments of the country. An active interpersonal teaching methodology has been employed, complemented by education through the mass media. The messages have concentrated on the survival and development themes of Facts for Life, but the project has also presented an opportunity for the education of women about their rights.

Children in especially difficult circumstances

22. The number of street and working children in Bolivia is small in absolute terms, but relatively high in proportion to the urban population. In collaboration with the Government and some 70 non-governmental organizations (NGOs), integrated services, including training, health care, food and shelter have been provided for 6,000 children and adolescents in the cities of La Paz, El Alto, Santa Cruz and Cochabamba. The advocacy efforts of institutions as diverse as the Central Labour Syndicate and the Catholic Church on behalf of children in especially difficult circumstances and all children led to the ratification of the Convention on the Rights of the Child. In addition, these advocacy efforts have set the stage for the revision of the legal Codigo del Menor (Code on Children and Youth), as a fundamental element in the protection of the Bolivian child.

Andean subregional programme on critical poverty

23. Although developed as part of a five-country programme of providing basic services in the areas of critical poverty in the Andean region, the Bolivian component of this programme has come to be considered as an integral part of the country programme in favour of children. Above all, the Andean subregional programme on critical poverty (PROANDES) has generated strong interest on the part of the Government, as well as in the donor community, in the most deprived areas of the country and in the promotion of child survival and development (CSD) among the poorest of the poor. More information on this programme is provided in a separate recommendation to the 1993 Executive Board (E/ICEF/1993/P/L.28).

Lessons learned

24. An analysis of UNICEF experience in Bolivia over the past four years (including the contribution of the multi-donor evaluation of UNICEF) indicates several areas in which the country programme could be further strengthened. Several lessons learned from past cooperation will be critical for success in the future: (a) the importance of keeping the child high on the political agenda by continuing advocacy and social mobilization involving all sectors of society; (b) the necessity of basing actions in favour of children, both in the short and long term, on a thorough assessment and analysis of the immediate and underlying factors that promote or inhibit CSD; (c) the need to improve national capabilities in monitoring and evaluating progress towards the country's stated goals; and (d) the importance of an explicit strategy to

promote women, not only as mothers, but as empowered participants in the development of the country.

RECOMMENDED PROGRAMME COOPERATION, 1993-1997

Recommended general resources: $ 6,875,000
Supplementary funding: $34,275,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health and nutrition	2 600	22 275	24 875
Education	1 850	9 500	11 350
Development for the Guaraní people	-	2 500	2 500
Social policies for children and women	1 145	-	1 145
Programme support	1 280	-	1 280
Total	6 875	34 275	41 150

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

The 10-year national plan of action for children and women

25. The Government of Bolivia has prepared a 10-year national plan of action for children and women to implement the goals and strategies of the World Summit for Children, as duly adapted to the realities of the country, and to accelerate implementation of the Convention on the Rights of the Child. A preliminary version of the plan was issued at the end of 1991, and a complete version in December 1992, on the second anniversary of the President's signing of the World Declaration and Plan of Action for the Survival, Protection and Development of Children in the 1990s. Among the major goals of the national plan of action are the following:

MAJOR SUMMIT GOALS FOR BOLIVIA

		1990 Baseline	2000 Goal
1.	IMR (per 1,000 live births)	102	50
	U5MR (per 1,000 live births)	147	70
2.	MMR (per 100,000 live births)	600	300
3.	Malnutrition		
	- % under-five malnutrition (underweight) - moderate and severe	13	7
4.	Water		
	- % access to safe drinking water	52	70
5.	Sanitation		
	- % access to sanitary means of excreta disposal	25	55
6.	Basic education		
	- Gross enrolment ratio at primary level	87	100
	- Grade one enrolment completing primary school	48	80
7.	Adult literacy rate (per cent)	78	89

26. The national plan of action for children and women is based in part on the analysis of the situation of children and women in Bolivia prepared with UNICEF support in 1992. The UNICEF programme of cooperation, in turn, has been prepared in line with the national plan of action, and its purpose is to support the Government in the achievement of some of the key objectives stated in that plan. It is recognized that the achievement of the goals for children in the 1990s will require action not only on the part of the Government and UNICEF, but the full participation of the donor community and Bolivian society at large. In view of the favourable response of various donors and the accelerated implementation of the current country programme, the amount proposed for supplementary funds has been increased in the new country programme. The supplementary contributions will allow the expansion and intensification of activities that will also be supported with general resources.

Programme strategies

27. The multi-donor evaluation of UNICEF has suggested an analysis of cooperation according to three programme strategies: (a) support to the delivery of specific services; (b) capacity-building for sustained programme delivery; and (c) empowerment of target group members. Based on an assessment of the problems and the most pressing needs of children and women in the

country, and analyses of the causes of those problems and of the opportunities available for addressing them, the programme of cooperation in Bolivia attempts to strike a balance among the three strategies.

28. Bolivia is a country with high IMR and U5MR, and a very high MMR. As such, the rapid reduction of those rates is the highest programme priority. Child development is a corollary of child survival; those factors which cause high rates of child deaths are much the same as those which prevent children from developing physically and intellectually into full participants in Bolivian society.

29. A sustained reduction in young child deaths, however, requires attention to the underlying causes of the problem. In the situation analysis, these factors are described as: (a) inadequate household food security; (b) inadequate care of children and women; (c) inadequate health, water supply and sanitation services; and (d) inadequate access to information and education. Actions addressed at such underlying causes include support to service delivery (e.g., the construction of water systems in Cochabamba and Potosí), but must be complemented by elements of capacity-building (e.g., training in the maintenance of water systems) if they are to be effective and self-sustaining.

30. The leading direct causes of maternal mortality - induced abortion, infection and toxaemia - can be attacked to some extent through improved service delivery and improved capacity to organize and maintain services. Yet the social factors which ultimately lead to high rates of maternal death are also associated with women's limited participation in society. The empowerment of women with respect to their rights, their education, their opportunities and their incomes is valid as a goal in itself, but is also crucial to a reduction in maternal mortality. Moreover, CSD cannot be separated from the social development of women. Bolivian women represent the country's least developed human resource - their empowerment to address their own needs and those of their children is a fundamental, if long-term, goal of the programme.

31. The analytical framework used in the situation analysis led to the logical selection of programme strategies. The need - and the opportunity - for a rapid reduction in mortality and morbidity indicators demand improved service delivery. Sustaining such improvements requires stronger formal and non-formal institutions. Opportunities for institution-building have been limited in the past by the lack of a permanent government civil service, although the inception of such a service is expected in 1993 and non-governmental service institutions are active. Finally, it is recognized that people with better access to and control over resources are in a better position to ensure their own well-being. Bolivia's ratification of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women offers new advocacy and mobilization opportunities for the broad empowerment of children and women.

32. The country programme of cooperation comprises national-scale programmes in the areas of social policies for children and women (including advocacy and social mobilization), health and nutrition, and education. The resources of the national-scale programmes will be employed with a view to the reduction of disparities within the country, targeting the departments of Chuquisaca, Potosí

and Cochabamba. In addition, concerted support will be provided for basic services and development of the Guaraní people of the Chaco region. The Bolivian component of PROANDES, presented separately to the Executive Board (E/ICEF/1993/P/L.28), will consolidate the progress made so far in the central Andean provinces of southern Cochabamba and northern Potosí, and expand its community-based activities into neighbouring provinces and departments.

33. These programmes and their component projects combine, in varying degrees, elements of the three programme strategies discussed in the multi-donor evaluation. The social policies programme is one primarily of institution-building and of empowerment through advocacy and mobilization for children's and women's rights. The health and nutrition, and education programmes include projects employing each of the three strategies. The area-based programmes include elements of service delivery and the development of skills and competence at the local level, but also provide unique opportunities for the direct empowerment of communities and, in particular, women.

Social policies for children and women

34. As a State Party to the United Nations Convention on the Rights of the Child and the United Nations Convention on the Elimination of All Forms of Discrimination Against Women, Bolivia has assumed important obligations under international law. Meeting the goals that the country has set for itself will require not only programmatic interventions of a sectoral nature, but also the continual promotion of a juridical, political and institutional environment which places children and women first. The programme of social policies for children and women responds to this need.

35. The process of review and revision, as necessary, of national laws to ensure their conformity to the terms of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women is under way and requires continued technical support. The programme will maintain a consultative system of orientation and advocacy on behalf of children and women with the Government, the Church, NGOs, organized labour, the private sector and the international community. Advocacy will be accompanied by mobilization as it will be essential to disseminate as widely as possible information on the Conventions, as well as on the 10-year national plan of action for children and women. This implies the full exploitation of the mass media and, at the community level, traditional channels of communication, to mobilize a movement for the survival, protection and development of children and the empowerment of women.

36. The strengthening of institutional capacity to formulate and analyse public policy with respect to the Conventions and the goals for children is essential to the success of the national plan of action. Of particular concern are the areas of social expenditure strategy, gender analysis and information management. In the country's present context of administrative decentralization, UNICEF will support training and technical assistance in these areas at departmental and national levels.

37. The programme also recognizes the need for improved national capabilities in monitoring the goals for children and women in the 1990s. All projects will

have built-in monitoring systems so that the Government can gauge their relative effectiveness. Additionally, a goal monitoring system will be established in the Government that will incorporate information from various governmental, NGO and donor institutions.

Health and nutrition

38. The programme for health and nutrition will support the Government in achieving the first three of the major goals for the 1990s: the reduction of the overall rates of infant and under-five mortality, maternal mortality and malnutrition. Strategically, the programme addresses the immediate as well as the underlying causes (as described in the situation analysis) of child and maternal deaths and malnutrition. At the level of immediate causes, actions will be directed against infectious diseases and problems of inadequate dietary intake. Such actions are relatively straightforward (e.g., ORT to prevent death from diarrhoeal dehydration, immunization against specific diseases and vitamin A supplements in the diet), but must be repeated indefinitely to be effective. Underlying causes are more complicated to address, but their correction can provide more durable and sustainable effects. These areas include the lack of preventive and curative health services (including access to adequate water supply and sanitation), inadequate care for children and women, lack of education and information, and insufficient household food security.. The programme addresses these problems on a nationwide level, except for water supply and sanitation (which for reasons of scale and cost, are limited in direct operational action to the area-based programmes) and household food security (also for reasons of scale, direct intervention is limited to the area-based programmes). Both water supply and sanitation and household food security, however, are subjects of national-level advocacy.

39. The programme comprises seven projects and a project support component: (a) institution-strengthening; (b) child health; (c) safe motherhood; (d) child feeding and the "baby-friendly" hospital initiative; (e) education and communication for women's health; (f) nutrition problem analysis for action; and (g) micronutrient deficiencies.

40. The project for institution-strengthening includes continued technical and training support for national, regional and district capacities in the planning, management and monitoring of primary health care activities. It will also include support to strengthen the health information management system and the managerial capacity of district-level health staff. Technical, logistical and supply support will also be provided for the country's fledgling essential drugs programme.

41. The child health project is a service delivery project aimed at the most important child-killing diseases through the expanded programme on immunization (EPI), the control of diarrhoeal diseases (CDD) and the control of ARI. For all three project components, UNICEF will provide supplies and equipment, technical and logistical support and funds for training. EPI aims at the eradication of poliomyelitis and the virtual elimination of neonatal tetanus by 1995, and a 95 per cent reduction in measles-related mortality by 1997. Universal immunization will require a combination of strategies - routine immunization at health facilities, outreach activities and mobile teams among dispersed rural populations all of which will be supported by vigorous

mobilization and communications activities. Actions for CDD will focus on the reduction of diarrhoea-related mortality through correct case management at household, community and health facility levels. The target is to reduce present diarrhoeal mortality rates by one half. The reduction of the incidence of diarrhoea will be addressed in other projects through the promotion of preventive measures such as prolonged breast-feeding; the use of clean water, improved personal hygiene and proper excreta disposal; and the correction of vitamin A deficiency. The control of ARI and the reduction of pneumonia-related mortality depend on four major strategies: (a) standard case management, including proper diagnosis and the appropriate use of antibiotics; (b) immunization against pertussis, diphtheria and measles; (c) mothers' recognition of the symptoms which indicate the need of medical care; and (d) in the long term, the reduction of risk factors.

42. The project for safe motherhood addresses maternal and perinatal mortality through more comprehensive prenatal care; the promotion of practices in maternity facilities that are more responsive to the needs and demands of Bolivian women; and the strengthening of the first level of referral, thereby increasing the rate of institutional deliveries by 30 per cent. UNICEF will finance the training of TBAs in safe delivery practices for women who, by choice or necessity, give birth at home. "Clean birth kits" for home use will also be provided. UNICEF will also support education and communication activities in reproductive health, including child spacing and sexually-transmitted diseases.

43. The central theme of the project to improve child feeding is the promotion of exclusive breast-feeding during the first four to six months of life and continued breast-feeding with complementary food well into the second year of life. UNICEF-supported actions will include applied research on improving the nutrient density of locally produced weaning foods; the training of health workers in the basic elements of child feeding; and the expansion of "baby-friendly" hospital concepts to all major maternity facilities throughout the country.

44. In the past programme of cooperation, women's health education had focused on the woman's role as mother, educating her primarily in the basic-knowledge required for the survival and development of her children. This element will remain in the present programme, but a new emphasis will be placed on women's care for themselves. The project combines the methodologies of interpersonal education and mass communication, and will reach some 110,000 women.

45. Reaching the goal for the reduction of malnutrition will also require the development of a national capacity for the assessment and analysis of nutritional problems. UNICEF will support the strengthening of the national nutrition surveillance system; the establishment of an action-oriented nutrition analysis unit in the Ministry of Planning; and the development of methodologies for community-based growth monitoring and promotion for application in the area-based programmes. Through training and the provision of supplies in conjunction with social mobilization, the micronutrient deficiencies project will address nutritional anaemia, vitamin A deficiency and IDD on a national level. Bolivia has set the goal of the elimination of IDD by 1995.

Education

46. In accordance with the recommendations made at the World Conference on Education for All, the education programme will strive to improve the quality of education offered, and to improve the achievement of children in basic education. Special attention is paid to the educational needs of the girl child and to the cultural and linguistic relevance of the education offered to indigenous children. The programme will support the implementation of national educational reform, young child-development, intercultural bilingual primary education, education for street children and working children, and women's education.

47. A working group within the Ministry of Planning is preparing a plan for a general reform of the country's educational system, which will be submitted for congressional approval in 1993. The reform is expected to give priority to basic education in rural areas - both in increasing access and in reducing grade repetition - and education for girls, and will receive strong advocacy and mobilization support from UNICEF.

48. The 10-year national plan of action calls for a massive increase in coverage and qualitative improvements in educational and developmental services for children aged six months to five years. The Government project for integrated child development will combine the resources of the Ministry of Health, the Ministry of Education and the Junta Nacional de Solidaridad y Desarrollo Social (National Council for Solidarity and Social Development) to reach more than 250,000 young children in marginal urban and rural areas. UNICEF will support training and technical assistance, to the direct benefit of some 52,000 children.

49. The past programme of cooperation has supported the development of multi-grade primary education, employing peer-teaching and other multi-grade methods. This methodology, necessitated by the low population density of the rural areas, will be combined with the further development and expansion of the very successful project for intercultural bilingual education. This project has been developing teaching materials and training teachers and supervisors in their use at the rate of one grade per year for three years for children whose mother tongue is Aymara, Quechua or Guaraní. Children who have participated in the pilot stages of the programme, and whose right it is to be educated in their own language and culture, have performed notably better than children whose first experience has been with the Spanish language only. The programme will develop materials for the full cycle of basic education, and will be expanded to serve 10,000 indigenous children by the end of the pilot phase in 1994, and 50,000 children by 1998.

50. An analysis of the situation of Bolivian children in especially difficult circumstances undertaken in 1991 has indicated that, in conjunction with legal protection, the greatest need of street children and working children is education. UNICEF will support the efforts of the Government and numerous NGOs to ensure the education of those children who must work to support their families, or who have no families or homes at all.

51. The education projects described above include a degree of gender focus. The disadvantages suffered by women from the day they enter the education

system as girls - or worse yet, are discouraged from doing so because they are girls - require special attention. A project for women's education and literacy will combine research, advocacy and mobilization with an educational perspective to enhance women's participation as full members of society.

Development of the Guaraní people

52. The Guaraní population of the Chaco region, numbering some 40,000 persons in rural areas, represent the third largest ethnic group in the country after the Aymara and the Quechua. The Guaraní are the most cohesive of the major ethnic groups, but are progressively disintegrating as a community because of critical poverty exacerbated by racial discrimination. In accordance with the stated Government priority of promoting the development of indigenous populations, UNICEF will provide support in the form of technical assistance, training, supplies and equipment to an integrated programme of advocacy, health, education and the empowerment of women in community development (including literacy and income generation) among the Guaraní.

Collaboration with other agencies

53. The programme of cooperation runs concurrently, complementarily and, in many cases, in direct collaboration with the programmes of the United Nations, international and bilateral agencies, as well as with the programmes of international and local NGOs. In particular, under Government coordination and guidance, the various elements of the UNICEF programme of cooperation complement the United Nations Development Programme Human Development Initiative; Pan American Health Organization (PAHO)/WHO support to child survival and women's health activities; the role of the United Nations Educational, Scientific and Cultural Organization in basic education; United Nations Population Fund support to reproductive health activities; United Nations Development Fund for Women and International Labour Organisation activities with respect to women's development; World Food Programme support to health care and integrated child development; World Bank activities in educational reform, health, child development and water supply and sanitation; Inter-American Development Bank activities in rural development; and the bilateral programmes of the United States of America, Germany, Switzerland, Spain, Holland, Belgium, Sweden and Italy, among others.

Programme development

54. The development of the programme of cooperation began with the preparation of a draft situation analysis based on a variety of studies and official information sources, and with input from governmental and non-governmental institutions. (The situation analysis will be updated, finalized and published when official data from the 1992 census become available in 1993.) As work on the situation analysis began, past UNICEF cooperation was systematically reviewed with government institutions and NGOs, first by sector and then in a mid-term programme review at the end of 1991. Following a combined strategy/programme preview meeting in March 1992, detailed programme planning was carried out with the relevant government offices, United Nations agencies (especially PAHO/WHO) and NGOs, in consultation with Ministry of Planning officials. Programme materials, including the situation analysis, were

presented to and discussed with representatives of all United Nations agencies in La Paz as they were developed.

Programme management

55. The UNICEF office in La Paz is under the direct responsibility of the UNICEF representative and comprises three areas of service: programme, external relations and operations (comprising the support functions of administration, personnel, finance and supply). The UNICEF representative has overall responsibility for representation; advocacy; programme formulation; and administration, funding, implementation, monitoring and evaluation of the programme of cooperation. In addition to other responsibilities, the external relations section is responsible for the critical area of advocacy for children and women, and the task of promoting an environment in which the terms of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women can be fulfilled, and in which the goals for children in the 1990s can be achieved.

56. Staff in the programme section are responsible for advocacy; the provision of technical advice to government and other institutions; programme formulation; and the administration, implementation, monitoring and evaluation of programmes and projects within their respective sectors. The programme section includes professional staff, both international and national, in health, nutrition, education, children in especially difficult circumstances, community development, water supply and sanitation, food production, communications, women in development and monitoring and evaluation. The professional staff working in the fields of communications, women in development and monitoring and evaluation, as well as the programme coordinator, are not considered to be sectoral specialists; rather, their responsibilities cut across the sectoral programmes. Because of its size, geographical focus and status as a subregional programme, PROANDES is managed separately, but in accordance with the policies and priorities established in the country programme of cooperation. In the context of Government administrative decentralization, a sub-office for PROANDES management is to be created in the departmental capital of Cochabamba, with an outposted officer (for food production) in northern Potosí.

Monitoring and evaluation

57. Components of rapid assessment or evaluation have been planned for each programme area. Sectoral and area-based programmes will be monitored and assessed on an annual basis through annual programme reviews at the national level. The entire country programme will be subject to a comprehensive mid-term review in 1996, at which time adjustments, if any, in strategies, priorities and resource allocation will be agreed upon between the Government and UNICEF. UNICEF will collaborate in the strengthening of the database on children and women with respect to core indicators on basic needs, as well as to process or service indicators for social sector policy formulation and effective service delivery. UNICEF will also collaborate with Government statistical agencies, as well as governmental and private research institutions

to generate quantitative and qualitative data and analysis on the general situation of children and women and other specific issues. Data obtained through national surveillance systems and their analysis will be published periodically in the interest of advocacy and formative evaluation for planning purposes.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Bolivia (1991 and earlier years) UNICEF country classification

Under-five mortality rate	126	(1991)	High U5MR	
Infant mortality rate	89	(1991)	Middle IMR	
GNP per capita	$ 650	(1991)	Lower-middle GNP	
Total population	7.4 Million	(1991)		

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1991
Births	(Thousands)	198	231	255	258
Infant deaths (under 1)	(Thousands)	30	28	23	23
Under-five deaths	(Thousands)	48	42	33	32
Under-five mortality rate (per 1,000 live births)		243	180	130	126
Infant mortality rate (under 1) (per 1,000 live births)		154	120	92	89

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1989)	Moderate & severe	..	13 a/
	Severe	..	3 a/
Babies with low birth weight (%, 1981/1987)		10	12
% of primary school children reaching final grade, 1988)		..	60*

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1977/1989)	93 /91/ 45	92 / 84 / 77
Prevalence of wasting (%, 1981/1989)	1	2
Prevalence of stunting (%, 1980/1989)	46	51 a/
Daily per capita calorie supply (% of requirements, 1988-1990)	..	84
Food production per capita index (Index 1979-1980=100, 1980/1991)	99	125
Household expenditure All food/cereals (% of total income, 1980-1985)		33 / ..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1991)			63
Access to health services	Total	..	63
(% of population, 1985)	Urban/rural	.. / ..	90 / 36
Access to safe water	Total	37	53
(% of population, 1980/1990)	Urban/rural	69 / 10	77 / 27
Access to adequate sanitation	Total	20	27
(% of population, 1980/1990)	Urban/rural	37 / 4	40 / 13
Births attended by trained personnel (%, 1989)		..	54
Maternal mortality rate (per 100,000 live births, 1990)		..	600

Immunization		1981	1985	1990	1991
One-year-olds (%) immunized against:	Tuberculosis	30	24	48	67
	DPT	13	33	41	58
	Polio	15	30	50	67
	Measles	17	21	53	73
Pregnant women (%) immunized against:	Tetanus	..	8	20	52

TABLE 1 (continued)

Bolivia

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%,1980/1990)	Total	84 / 77	82 / 79
	Male	90 / 82	87 / 83
	Female	78 / 72	78 / 75
Secondary enrolment ratio (gross/net) (%, 1980/1990)	Total	36 / 16	34 / 28
	Male	41 / 18	37 / 30
	Female	31 / 14	31 / 25
Adult literacy rate, 15 years & older (%, 1970/1990)	Total	57	78
	Male/female	68 / 46	85 / 71
Radio/television sets (per 1,000 population, 1990)		503 / 54	599 / 163

DEMOGRAPHIC INDICATORS		1970	1980	1990	1991	2000**
Total population	(Thousands)	4325	5581	7171	7346	9038
Population aged 0-15 years	(Thousands)	1969	2555	3133	3185	3644
Population aged 0-4 years	(Thousands)	740	947	1093	1110	1252
Urban population (% of total)		41	44	51	52	58
Life expectancy at birth (years)	Total	46	54	60	61	65
	Male	44	51	58	58	62
	Female	48	56	62	63	67
Total fertility rate		6.5	5.8	4.8	4.7	3.9
Crude birth rate (per 1,000 population)		46	41	36	35	31
Crude death rate (per 1,000 population)		20	14	10	10	8

		About 1980	Most recent
Contraceptive prevalence rate (%, 1983/1989)		26	30
Population annual growth rate (%, 1965-1980/1980-1991)	Total	2.5	2.5
	Urban	2.9	3.9

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1991)		1.7	-2.0
Inflation rate (%, 1965-1980/1980-1990)		16	318
Population in absolute poverty (%, 1975/1990)	Urban/rural	.. / 85	30*/ 50*
Household income share (%, 1980-1988)	Top 20%/bottom 40%	58*/ 12*	.. / ..
Government expenditure (% of total expenditure, 1980/1990)	Health/education	12 / 27	2 / 18
	Defence	18	14
Household expenditure (% of total income, 1980-85/1990)	Health/education	5 / 7	4* / 5*
Official development assistance: (1980/1991)	$US millions	170	540
	As % of GNP	5	11
Debt service (% of goods and services exports, 1980/1990)		28	29

a/ Indicates data that differ from the standard definition or refer to only part of a country.
* UNICEF field office source.
** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1989–1992 a/

COUNTRY: BOLIVIA
LATEST BOARD APPROVAL: 1989
GENERAL RESOURCES: $5,270,000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	1286	2202	289	633	663	195	1343	2829	3581	2870	5859	14340	9440	17210
Nutrition and goitre control	124	1259	115	128	106	729	223	1747	568	500	3863	8438	4431	8938
Water supply and sanitation		1103		36		194		787			2120	1878	2120	1878
Education	64	279	99	763	365	603	413	2495	941	900	4140	6412	5081	7312
Community organization and development		323		82		257	8	651	8		1313	1470	1321	1470
Children in especially difficult circumstances		145		8		133	2	585	2		871	1900	873	1900
Social policies	97	131	58	9	17	249	532	303	704	1000	692	683	1396	1683
Programme support					788				788				788	
Emergency	53								53	50			53	50
GRAND TOTAL	1624	5442	561	1659	1939	2360	2521	9397	6645 b/	5320 c/	18858 d/	35121 d/	25503	40441 e/

GR = General resources.
FSF = Funded supplementary funding.
SF = Supplementary funding, funded and unfunded.
a/ Actual expenditure includes expenditure recorded as of 17 December 1992.
b/ Including expenditure from global funds.
c/ Including $50,000 from the Emergency Reserve Fund.
d/ Including actual expenditure and planned for the Andean subregional programme (PROANDES).
e/ Of this amount, $12,600,000 was not funded.

TABLE 3. PLANNED EXPENDITURE, 1993 – 1997

(In thousands of United States dollars)

Country: BOLIVIA Period covered: 1993 – 1997	Funding status	1993	1994	1995	1996	1997	Total
Health	GR	570	525	520	495	490	2600
	FSF	2213	307				2520
	NSF	4700	4700	4700	4600	3575	22275
Education	GR	375	400	375	350	350	1850
	FSF	356					356
	NSF	1940	2120	2040	1800	1600	9500
Social policies for children and women	GR	220	220	225	250	230	1145
Programme support	GR	210	230	255	280	305	1280
Integrated area–based programme for Guarani	NSF	400	600	575	575	350	2500
TOTAL	GR	1375	1375	1375	1375	1375	6875
	FSF a/	2569	307				2876
	NSF a/	7040	7420	7315	6975	5525	34275
GRAND TOTAL		10984	9102	8690	8350	6900	44026

GR = General resources.
FSF = Funded supplementary funding.
NSF = New supplementary funding.
a/ This amount does not include funded supplementary funding and new supplementary funding for the Andean subregional programme (PROANDES).

TABLE 4. LINKAGE OF PROGRAMME BUDGET AND STAFFING/STAFF COSTS

BOLIVIA

PROGRAMME SECTION/AREAS AND FUNDING SOURCES	PROGRAMME BUDGET, 1993–1997 (In thousands of US dollars)				POSTS a/ and b/									TOTAL POSTS	STAFF COSTS c/ (In thousands of US dollars)		
					EXISTING POSTS						SUBTOTAL						
	GR	FSF	NSF	TOTAL	D2/L7	D1/L6	P/L5	P/L4	P/L3	P/L2	IP	NP	GS		IP	LOCAL	TOTAL
GENERAL RESOURCES																	
Health and nutrition	2600			2600				1			1	1	1	3	670	340	1010
Education	1850			1850													
Social policies for children and women	1145			1145													
Programme support	1280			1280								1	10	11		880	880
TOTAL GR	6875			6875				1			1	2	11	14	670	1220	1890
SUPPLEMENTARY FUNDING																	
Health and nutrition		2213	22275	24488					1		1	2	6	9	610	1030	1640
Education		270	9500	9770				1			1	3	3	7	680	940	1620
Integrated area-based programme			2500	2500													
TOTAL SF		2483	34275	36758				1	1		2	5	9	16	1290	1970	3260
TOTAL GR & SF				43633				2	1		3	7	20	30	1960	3190	5150
ADM. AND PROGRAMME SUPPORT BUDGET (Proposed, 1994–1995)	Operating costs			1400													
	Staffing b/						1	1			2	3	11	16	509	725	1234
GRAND TOTAL (GR + SF + ADM)							1	3	1		5	10	31	46			
	Number of posts and staff costs:																
	- At the beginning of previous programme (1989)										8	11	26	45	N/A	N/A	N/A
	- At the beginning of proposed programme (1993)										5	10	31	46	N/A	N/A	N/A
	- At the end of proposed programme (1997) **(Indicative only)**										5	10	31	46	N/A	N/A	N/A

a/ Each post, regardless of its funding source, supports the country programme as a whole.

b/ The posts excluding the Andean subregional programme (PROANDES) are effective as of 1 January 1994.

c/ Project posts are funded for five years and core posts are funded for two years.

Abbreviations: GR = general resources; FSF = funded supplementary funding; NSF = new supplementary funding; SF = supplementary funding; IP = International Professional; NP = National Professional; GS = General Service; ADM = administrative.